

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13047

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13041

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gallant Green</i>		c. LENGTH OF STAY IN lb <i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>LEONARD JOHN BENDER</i>		4. DATE OF DEATH Month <i>12</i> Day <i>16</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 8 1935</i>
9. AGE (In years last birthday) <i>22</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>FRED BENDER</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Ploor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		16. SOCIAL SECURITY NO. <i>54-56</i>	
17. INFORMANT <i>FRED BENDER</i>		Address <i>WALDORE MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Internal hemorrhage</i> <i>835X</i> DUE TO <i>Tractor fell on him</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Tractor turned over on him</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>12-16-57</i> <i>12-16-57</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Tractor turned over on him</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>4:45</i> a. m. <i>12-16-57</i> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Farm</i>		20f. (City or town) <i>Gallant Green</i> (County) <i>Charles</i> (State) <i>md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		DATE SIGNED <i>12-16-57</i>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-19-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's Cem.</i>		22d. LOCATION (City, town, or county) <i>BRYANTOWN MD.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HUNT FUNERAL HOME</i>		ADDRESS <i>WALDORE, MD.</i>	
24a. REC'D BY REGISTRAR <i>12/20/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia Hasey</i>	

STATE DEPARTMENT OF HEALTH - BATHING IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME *John*
RESIDENCE *Wichita (Ks.)*

BUREAU V. S.

DEC 23 1957

RECEIVED

VS. AISME
SM 2/57

1. PLACE OF DEATH a. COUNTY		Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Welcome		26 yrs.		Welcome			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First JOSEPH		Middle WILLIAM		Last BOWIE	
4. DATE OF DEATH		Month December		Day 11		Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/19/30		9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Service Station Operator				Pezah Md		u S a	
13. FATHER'S NAME Benjamin Bowie				14. MOTHER'S MAIDEN NAME Mary E. Simpson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-24-4155		17. INFORMANT Benjamin F. Bowie		Address Welcome, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R S Fisher MD				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/12/57	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12-14-57		Benjaminoy Baptist		Benjaminoy Md	
23. FUNERAL DIRECTOR'S SIGNATURE Archibutric Lopsdale Md				24a. REC'D BY REGISTRAR DATE 12/16/57		24b. REGISTRAR'S SIGNATURE Julius H. Rosen	

RECEIVED

DEC 19 1957

BUREAU V. S.

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13048 87001

CERTIFICATE OF DEATH

13042

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laplata</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Laplata</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phy. Mem Hosp</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Jones Burdette</u>				4. DATE OF DEATH Month Day Year <u>Dec 24 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 23, 1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Delumbre</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George A Jones</u>				14. MOTHER'S MAIDEN NAME <u>Eunus Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address <u>Dorothy Morris Laplata Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior Myocardial Infarction, acute 2 days</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>19 Dec.</u> , 19 <u>57</u> , to <u>24 Dec.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>23 Dec.</u> , 19 <u>57</u> , and that death occurred at <u>5:33 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V.B. Detton</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Box 397 LAPLATA, MD 24 DEC 1957</u>			
PHYSICIAN'S NAME (Type) <u>V.B. DETTON, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Rest</u>		22d. LOCATION (City, town, or county) (State) <u>Laplata Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rehner Inc Laplata</u>				ADDRESS <u>Laplata</u>		24a. REC'D BY REGISTRAR DATE <u>12/30/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Julia H Paresy</u>			

BUREAU V. 3.

3 JAN 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or interment.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13044

13050

Reg. Dist. No.

106

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn NY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Powder Factory Dispensary, Indian Head Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Brooklyn NY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn NY d. STREET ADDRESS 54-Doscher St. Brooklyn, NY. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Michael A. Costagliola		4. DATE OF DEATH Month 12 Day 18 Year 57	
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-34
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Enlisted-US-Army		10b. KIND OF BUSINESS OR INDUSTRY US-Army	
11. BIRTHPLACE (State or foreign country) Brooklyn-NY.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1-21-57 to 12-18-57	
17. INFORMANT Eugene McEntee-Yoe-2C-, USN-Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries Multiple Extreme DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Explosion 5-In. Rocket Fuse DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury occurred when fuse exploded while patient was on duty at Stump Neck Annex, Naval Powder Factory Indian Head Md.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 9:30-AM-12-18-57 p. m.		20d. INJURY OCCURRED Nat while at work <input checked="" type="checkbox"/> Nat while at work <input type="checkbox"/> Unknown	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Indian Head, Charles, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James E. Andrews MD.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Indian Head Md		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-18-57	
22a. BURIAL CREMATION REMOVAL (Specify) Removed		22b. DATE THEREOF 12-18-57	
22c. NAME OF CEMETERY OR CREMATORY W.W. CHAMBERS CO 1400 CHAPIN ST NW		22d. LOCATION (City, town, or county) (State) New York City, NY.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO		24a. REC'D BY REGISTRAR ODEY PRICE	
ADDRESS 1400 CHAPIN ST NW		24b. REGISTRAR'S SIGNATURE ODEY PRICE	

MEDICAL CERTIFICATION

2

BUREAU V. S.

DEC 23 1957

RECEIVED

13051

CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wayside</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X1 Wayside</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>E</i> Last <i>Edwards</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>11</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 1, 1879</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>St Marys Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Thomas E Edwards</i>		14. MOTHER'S MAIDEN NAME <i>Mary F Lloyd</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>John H. Edwards</i>		Address <i>Wayside</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary artery disease</i> DUE TO (c) <i>Atherosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 mi</i> <i>5 year</i> <i>10 year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Howe</i> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-14-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Ghost</i>	22d. LOCATION (City, town, or county) (State) <i>md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anchor Inc</i>		24. REC'D BY REGISTRAR <i>Kaplata</i>	24b. REGISTRAR'S SIGNATURE <i>Julia Hasey</i>
		DATE <i>12/17/57</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

FILE NO. 100-1000

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. OCCUPATION [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MANNER OF DEATH [Faint text]</p>		<p>10. MEDICAL HISTORY [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. DATE OF DEATH [Faint text]</p>		<p>14. TIME OF DEATH [Faint text]</p>	
<p>15. PLACE OF INTERMENT [Faint text]</p>		<p>16. NAME OF INTERMENT PLACE [Faint text]</p>	
<p>17. NAME OF FUNERAL HOME [Faint text]</p>		<p>18. NAME OF FUNERAL HOME [Faint text]</p>	
<p>19. NAME OF FUNERAL HOME [Faint text]</p>		<p>20. NAME OF FUNERAL HOME [Faint text]</p>	
<p>21. NAME OF FUNERAL HOME [Faint text]</p>		<p>22. NAME OF FUNERAL HOME [Faint text]</p>	
<p>23. NAME OF FUNERAL HOME [Faint text]</p>		<p>24. NAME OF FUNERAL HOME [Faint text]</p>	
<p>25. NAME OF FUNERAL HOME [Faint text]</p>		<p>26. NAME OF FUNERAL HOME [Faint text]</p>	
<p>27. NAME OF FUNERAL HOME [Faint text]</p>		<p>28. NAME OF FUNERAL HOME [Faint text]</p>	
<p>29. NAME OF FUNERAL HOME [Faint text]</p>		<p>30. NAME OF FUNERAL HOME [Faint text]</p>	
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<p>97. NAME OF FUNERAL HOME [Faint text]</p>		<p>98. NAME OF FUNERAL HOME [Faint text]</p>	
<p>99. NAME OF FUNERAL HOME [Faint text]</p>		<p>100. NAME OF FUNERAL HOME [Faint text]</p>	

BUREAU V. 2

DEC 20 1957

RECEIVED

13052

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Victoria</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Victoria</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Fannie SALES</i>		4. DATE OF DEATH Month Day Year <i>DEC 22 1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 7</i>
9. AGE (In years lost birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Henry Dyson</i>		14. MOTHER'S MAIDEN NAME <i>Frances Anna Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT Address <i>2913 Baker St. Balt. Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular occlusion</i> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>out</i> , 19 <i>55</i> , to <i>12-22</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12-21</i> , 19 <i>57</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F. M. Johnson</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>LA PLATA Md. 12-23-57</i>	
PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec. 26, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Shiloh M.E.</i>		22d. LOCATION (City, town or county) (State) <i>Hayside Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 30 '57</i>	
		24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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BUREAU Y. E.

DEC 30 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

116

13053

1. PLACE OF DEATH a. COUNTY <u>Chas</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Adrian GARNER</u>				4. DATE OF DEATH Month Day Year <u>Dec 29 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 28, 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>RICHARD GARNER</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. WELCH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS RUTH Goldsmith Bel Alton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory collapse</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C.U.A.</u> DUE TO (c) <u>Essential hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>previous CUA 7 years ago</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>29 Dec</u> , 19 <u>57</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Arthur Woodydy</u> M.D.				<u>Sarwood Chime</u> 30 Dec 57			
PHYSICIAN'S NAME (Type) <u>ARTHUR WOODYDY, MD</u>				<u>LA PLATA, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ARIAL</u>		22b. DATE THEREOF <u>12-31-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Ignatius CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BEL ALTON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HUNT Funeral Home WILCOX, MD.</u>				24a. REC'D BY REGISTRAR <u>31 JAN 3 1958</u> 24b. REGISTRAR'S SIGNATURE <u>John R. [Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-1-10

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. TIME OF DEATH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]		9. PLACE OF BIRTH [Faint text]	
10. OCCUPATION [Faint text]		11. EDUCATION [Faint text]		12. MARITAL STATUS [Faint text]	
13. PREVIOUS MARRIAGES [Faint text]		14. SERVICE RECORD [Faint text]		15. OTHER NOTES [Faint text]	
16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF WITNESS [Faint text]		18. SIGNATURE OF PHYSICIAN [Faint text]	
19. SIGNATURE OF CORONER [Faint text]		20. SIGNATURE OF JUDGE [Faint text]		21. SIGNATURE OF CLERK [Faint text]	

BUREAU V. S.

IAN 3 1958

RECEIVED

13054

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Waldorf</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial Hosp.</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First <i>Maude</i> Middle <i>E.</i> Last <i>Glazeman</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>5</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 3 1883</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
11. BIRTHPLACE (State or foreign country) <i>Minnesota</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Jens Hansen</i>		14. MOTHER'S MAIDEN NAME <i>Anne Olson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>A. R. Glazeman</i>		Address <i>Waldorf, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Acute Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) <i>(Cardiac Arrest on 12-3-57)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i> <i>2 YRS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>January 1951</i> to <i>December 5, 1957</i> , that I last saw the deceased alive on <i>Dec. 5</i> , 1957, and that death occurred at <i>9:20 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Larson Jarboe</i>		DATE SIGNED <i>12-5-57</i>	
PHYSICIAN'S NAME (Type) <i>J. PARRAN JARBOE, M.D.</i>		ADDRESS <i>La Plata, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>12-7-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>LEE Funeral Home</i>	22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>HUNT Funeral Home</i>		24a. REC'D BY REGISTRAR DATE <i>12/9/57</i>	24b. REGISTRAR'S SIGNATURE <i>Julia H. Boney</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		NATURAL		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.	
DETAILS OF CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH	
CORONARY ARTERY DISEASE		NATURAL		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.	
DETAILS OF CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH	
CORONARY ARTERY DISEASE		NATURAL		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.	

BUREAU V. 2

DEC 11 1957

RECEIVED

13055

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Mr Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b X2 Waldorf			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hosp.				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JULIANA First Middle Last LANGLEY				4. DATE OF DEATH Month Dec Day 20 Year 19 57			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-74		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unk				14. MOTHER'S MAIDEN NAME unk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Clements Langley		Address Waldorf, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Atherosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 18 Dec. 19 57 , to 20 Dec. 19 57 , that I last saw the deceased alive on 20 Dec. 19 57 , and that death occurred at 10:01 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE V. B. DETTOR				ADDRESS (Street, city or town, state) LA PLATA, MARYLAND.			
PHYSICIAN'S NAME (Type) V. B. DETTOR, M.D.				DATE SIGNED 12-22-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-23-57		22c. NAME OF CEMETERY OR CREMATORY St Peters Cem.		22d. LOCATION (City, town, or county) Waldorf, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home				ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR DATE 12/30/57	
				24b. REGISTRAR'S SIGNATURE Julia H. Hasey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 3 1953
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or other disposition of the remains.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13051

Reg. Dist. No.

100

13056

1. PLACE OF DEATH a. COUNTY <i>Charles</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Iron side md.</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO Indian Head md.</i> d. STREET ADDRESS <i>1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Jerome</i> Middle <i>David</i> Last <i>Montgomery</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>25</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 2 1929</i>
9. AGE (In years last birthday) <i>25</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Gov worker</i>	
11. BIRTHPLACE (State or foreign country) <i>Charles co</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Russell Montgomery</i>		14. MOTHER'S MAIDEN NAME <i>Evelyn A. Wiseman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Laveria Montgomery Indian Head Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock & Hemorrhage</i> 981X DUE TO <i>Gun shot wound of left face</i> Conditions, if any, which gave rise to immediate cause (b) <i>2-3 min.</i> (c) <i>2-3 min.</i> DUE TO <i>cause lost.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Shotgun wound</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>6:10</i> P.M. <i>12-25-1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Ironside, Charles, Md.</i> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>V.B. Detlor</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>V.B. DETTOR, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>12-25-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>11-29-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Grave Hope Church</i>		22d. LOCATION (City, town or county) <i>Iron side Md</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Montgomery Brothers Funeral Home</i>		24a. REC'D BY REGISTRAR <i>12/25/57</i>	
		24b. REGISTRAR'S SIGNATURE <i>Julius Pacey</i>	

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

John J. [illegible]

John J. [illegible]

John J. [illegible]

John J. [illegible]

John J. [illegible]

John J. [illegible]

John J. [illegible]

John J. [illegible]

John J. [illegible]

BUREAU V. S.

JAN 3 1933

RECEIVED

13057

Item 2; See Item 17

CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH o. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial</u>				d. STREET ADDRESS <u>--</u>			
3. NAME OF DECEASED (Type or print) First <u>BAOY</u> Middle <u>MOORE</u> Last <u>MOORE</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 28 1957</u>	9. AGE (In years last birthday) <u>2</u> years	IF UNDER 1 YEAR Months <u>2</u> Days <u>45</u>	IF UNDER 24 HRS. Hours <u>2</u> Min. <u>45</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Laplata md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward H Moore</u>				14. MOTHER'S MAIDEN NAME <u>Jannet Morin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Edward H Moore</u>		17. INFORMANT Address <u>Waldorf md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory collapse</u> <u>758.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chondrodysplasia (achondroplasia)</u> DUE TO (c) <u>2 hrs. 45 min</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-28</u> , 19 <u>57</u> , to <u>12-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-28</u> , 19 <u>57</u> , and that death occurred at <u>7:00</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. M. JOHNSON</u> M.D.				ADDRESS (Street, city or town, state) <u>La Plata Md</u> DATE SIGNED <u>12-28-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wendell Mc Laplata md</u> ADDRESS <u>Waldorf md</u>				24a. REC'D BY REGISTRAR <u>DEC 31 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Julius Posyp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2066285XVV

BUREAU V. S.

DEC 31 1957

RECEIVED

13053

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Thompsville md</u> , MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles Co</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ELIZABETH MOORE</u>		4. DATE OF DEATH <u>DEC 22 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov 2 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>	
11. IF UNDER 24 HRS. Hours <u>10</u> Min. <u>8</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Co</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Mo's ai</u>			
13. FATHER'S NAME <u>George Roy</u>		14. MOTHER'S MAIDEN NAME <u>Lena Colbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Carrie Thomas Thompsville md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition and Senility</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>V. B. Dettor</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V. B. DETTOR, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>		22d. LOCATION (City, town, or county) (State) <u>Issue md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archer Mc Saplata md</u>		24a. REC'D BY REGISTRAR <u>Julia Hoseney</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.

RECEIVED

JAN 3 1938

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1205

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
OFFICE OF EXAMINER: [illegible]

13059

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomfret</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Pomfret</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>FRANCIS</u> First <u>MUDD</u> Middle <u>MUDD</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-01</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. MUDD</u>		14. MOTHER'S MAIDEN NAME <u>Constance MUDD.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213 38 224</u>	
17. INFORMANT <u>Evelyn MUDD</u> Address <u>Pomfret, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen. ART Sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12-6-57</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-10</u> , 19 <u>57</u> , to <u>12-6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-27</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Lafayette</u> DATE SIGNED <u>12-8-57</u>			
ACTUAL SIGNATURE <u>E. J. EDELEN</u> M.D.			
PHYSICIAN'S NAME (Type) <u>E. J. EDELEN MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-9-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Joseph's</u>	22d. LOCATION (City, town, or county) (State) <u>Pomfret, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT Funeral Home</u> ADDRESS <u>WALDORF MD.</u>		24a. REC'D BY REGISTRAR DATE <u>12/9/57</u>	24b. REGISTRAR'S SIGNATURE <u>Julia H. H. H.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13060

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13055

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Doncaster</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Doncaster</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Alfred</u> Last <u>Myatt</u>				4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-23-1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Myatt</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Stallings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Mrs. Esther Blandy, Smithfield, N.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Artery Occlusion</u> <u>Minutes</u> (a), stating the underlying cause lost. DUE TO (c) <u>Arteriosclerotic Heart Disease.</u> <u>Years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None known</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> a. m. <u>12-5-</u> p. m. <u>1957</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Doncaster Charles Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Vernon B. Dettor</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-7-'57</u>	
EXAMINER'S NAME (Type) <u>Vernon B. Dettor, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12-7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithfield N.C.</u>		22d. LOCATION (City, town, or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Weldoy Md</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>12/9/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Julia H. Hosen</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3060

RECEIVED
DEC 11 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13061 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13056

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) <u>George Arthur</u> First <u>Robey</u> Middle Last 4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1957</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan 4, 1910</u> 9. AGE (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____ 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
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13. FATHER'S NAME <u>James L. Robey</u>	14. MOTHER'S MAIDEN NAME <u>Mary J. Dixon</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. <u>218-30-2715</u>	17. INFORMANT <u>Ann Mary Robey Bryantown Md</u> Address _____
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular Disease</u> (a), stating the underlying cause lost. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year _____ Hour _____ a. m. _____ p. m. _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____

21. I certify that I took charge of the remains described above, held an Autopsy ☒ **Inspection** ☐ **Inquiry** ☐ **and find that death resulted from:** Natural causes ☒ **Accident** ☐ **Suicide** ☐ **Homicide** ☐ **Undetermined cause** ☐.

ACTUAL SIGNATURE <u>William Updett</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) _____ ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> _____ DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>12-22-57</u>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Dec. 26, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>	22d. LOCATION (City, town, or county) <u>Bushwood</u> (State) <u>Md.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntz Fun. Home</u> ADDRESS <u>Waldorf, Md.</u>	24a. RECEIVED BY REGISTRAR <u>DEC 30 1957</u> DATE _____	24b. REGISTRAR'S SIGNATURE <u>John Posey</u>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18
STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y. S.

DEC 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or other disposition.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13057

Reg. Dist. No. 106

13062

1. PLACE OF DEATH a. COUNTY Charles			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Rhode Island b. COUNTY Providence, RI		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stump Neck, Naval Powder Factory Annex Indian Head Md.			c. LENGTH OF STAY IN 1b Unknown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Powder Factory Dispensary Indian Head Md.			d. STREET ADDRESS 789-Greenville Ave. Johnson, RI		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Sanderson, Nelson Lloyd			4. DATE OF DEATH Month 12 Day 18 Year 57		
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-39	9. AGE (In years last birthday) 18 yrs.	IF UNDER 1 YEAR Months 12 Days 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF		10b. KIND OF BUSINESS OR INDUSTRY Military		11. BIRTHPLACE (State or foreign country) Providence RI.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 9-13-56		
17. INFORMANT Eugene McEntee-Yoe.-2C-USN-Records			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries Multiple Extreme DUE TO 916.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Explosion 5In.Rocket Fuse DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
None					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury occurred when a 5-In.Rocket fuse exploded while patient was on duty at Stump Neck Annex, Naval Powder Factory, Indian Head Md.			
20c. TIME OF INJURY Month, Day, Year 9:30 a.m. 12-18-57		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown	
20f. (City or town) Indian Head		20g. (County) Charles,		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE James E. Andrews		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-18-57	
EXAMINER'S NAME (Type) James E. Andrews MD Indian Head Md		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removed		22b. DATE THEREOF 12-18-57		22c. NAME OF CEMETERY OR CREMATORY Swan Point Cemetery	
22d. LOCATION (City, town, or county) Providence		22e. (State) Rhode Island			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chamber Co. 517-11th St. S.E.			24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Olley Price

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOWED		DIVORCED	
OCCUPATION		EDUCATION		RELIGION		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE	
SIGNATURE OF MEDICAL EXAMINER		DATE		TIME		PLACE		CITY		STATE	

BUREAU V. S.

DEC 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13063

CERTIFICATE OF DEATH

Reg. Dist. No. **13058**

1. PLACE OF DEATH a. COUNTY <u>Charles Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE _____ b. COUNTY <u>Charles</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Rock Point Md.</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phy mem Hspt</u>						d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle _____ Last <u>SMOTHERS</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>14</u> Year <u>1957</u>									
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 8, 1890</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Labour</u>				11. BIRTHPLACE (State or foreign country) <u>Charles Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Lerry</u>						14. MOTHER'S MAIDEN NAME <u>Mary Young</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Blanch Smothers (Wife)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous Cell Carcinoma of face</u> 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour a. m. _____ p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>56</u> , to <u>14 Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 Dec</u> , 19 <u>57</u> , and that death occurred at <u>2:10 P.M.</u> , from the causes and on the date stated above.													
ACTUAL SIGNATURE <u>F. M. JOHNSON</u> M.D.						ADDRESS (Street, city or town, state) <u>Ka. Plate, Md.</u> DATE SIGNED <u>12-17-57</u>							
PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON M.D.</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>				22d. LOCATION (City, town, or county) (State) <u>Issue Md. Charles Co</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Orsted Inc</u>						ADDRESS <u>Lyndale Md</u>				24a. REC'D BY REGISTRAR DATE <u>12/20/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia B. Passey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13064 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give address/town) <i>Laplata Md</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Rock Point Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>Mem Hosp</i>				d. STREET ADDRESS <i>1</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>SHARON ANN SMOTHERS</i>				4. DATE OF DEATH <i>DEC 9 1957</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 28, 1954</i>	9. AGE (In years last birthday) <i>3</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Rock Point</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John W. Smathers Jr</i>				14. MOTHER'S MAIDEN NAME <i>Lessie C. Dyson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John W. Smathers Jr Rock Point Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>3rd degree burns over 1/5 body</i>							<i>3 days</i>
916.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							(b) DUE TO
							(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Kerosene stove blew up</i>			
20c. TIME OF INJURY Hour a. m. p. m.	Month. Day. Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Rock Pt.</i>	(County) <i>Chas.</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>12-7-57</i> , to <i>12-9-57</i> , that I last saw the deceased alive on <i>12-9-57</i> , 1957, and that death occurred at <i>9:15 PM</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Dr. Laplata</i>				ADDRESS (Street, city or town, state) <i>La Plata, Md.</i>			
DATE SIGNED <i>12-9-57</i>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>12-11-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Ghost</i>		22d. LOCATION (City, town, or county) (State) <i>Chas. Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chehart Inc</i>				ADDRESS <i>Laplata Md</i>		24a. REC'D BY REGISTRAR DATE <i>12/16/57</i>	24b. REGISTRAR'S SIGNATURE <i>Julia M. Posey</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13065 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13060

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTSVILLE</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO DENTVILLE MD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HANS</u> Middle <u>OTTO</u> Last <u>STASCH</u>				4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-11</u>		9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Mgnths Days Hours Min.	IF UNDER 24 HRS. Mgnths Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>ST MARYS CO USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>AUGUST</u>				14. MOTHER'S MAIDEN NAME <u>DORTHFA RADIES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>OTTO H STASCH</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>822x</u> DUE TO <u>Couflagration and Crusher Chert</u> Conditions, if any, which gave rise to immediate cause (b) <u>Tractor turned over on him</u> (c), stating the underlying cause last. <u>and caught fire</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12-12-57</u> <u>12-12-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tractor turned over on him and caught fire</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12</u> p. m. <u>12</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Dentsville char Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. J. EDELEN</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-12-57</u>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST PAULS</u>		22d. LOCATION (City, town, or county) (State) <u>CHARLOTT HALL MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archard 2nd Squata mol</u>				24a. REC'D BY REGISTRAR DATE <u>12/17/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H Pacey</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEC 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13066

Items 13.11, Film G223 12-27-57 et

CERTIFICATE OF DEATH

13061

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Point</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Rock Point</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>AGUSTUS</i> Middle <i>STINE</i> Last		4. DATE OF DEATH Month <i>Dec</i> Day <i>12</i> Year <i>1957</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 24 1873</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Optician + Fisherman</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Raymond Stine Rock Point</i>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive Heart Failure</i> (c) <i>Arteriosclerotic Heart Disease</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i> <i>3 weeks</i> <i>years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no injury</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>8:50 p.m.</i> <i>12 12 1957</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rock Point, Charles, Md.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>29 Oct.</i> , 19 <i>57</i> , to <i>29 Nov.</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>29 Nov.</i> , 19 <i>57</i> , and that death occurred at <i>8:50 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Vernon B. Dettor</i>		ADDRESS (Street, city or town, state) <i>Box 397, LA PLATA, MD.</i> DATE SIGNED <i>14 DEC. 1957</i>	
PHYSICIAN'S NAME (Type) <i>VERNON B. DETTOR</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-16-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Ghost</i>		22d. LOCATION (City, town, or county) (State) <i>Ind Charles</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rehoboth Inc La Plata</i>		24a. REC'D BY REGISTRAR DATE <i>12/17/57</i>	
24b. REGISTRAR'S SIGNATURE <i>Julia H. Posen</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10

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REFERENCES

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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27/10/20

BUREAU V. S.

DEC 20 1957

RECEIVED

13067 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> <i>and</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phy</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tompkinsville x2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phy Mem. Hoyet</i>				d. STREET ADDRESS <i>1</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Warren Biscoe Thompson</i>				4. DATE OF DEATH Month Day Year <i>12 - 12 1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/17/1886</i>	9. AGE (In years last birthday) <i>71</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>forming</i>		11. BIRTHPLACE (State or foreign country) <i>Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Emuel Thompson</i>				14. MOTHER'S MAIDEN NAME <i>Bliss Poily</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Lillian Thompson</i>		Address <i>Tompkinsville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> <i>420.1</i> DUE TO <i>Arteriosclerotic Cardiovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>3 yrs</i> (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Dec 5</i> , 19 <i>57</i> , to <i>Dec 13</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Dec 13</i> , 19 <i>57</i> , and that death occurred at <i>4:25</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. Parran Jarboe</i> M.D.				ADDRESS (Street, city or town, state) <i>La Plata Md</i> DATE SIGNED <i>12-13-57</i>			
PHYSICIAN'S NAME (Type) <i>J-PARRAN JARBOE</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12-16-57</i>		<i>Holy Ghost</i>		<i>2 mi md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Anchor Inc La Plata</i>				24a. REC'D BY REGISTRAR DATE <i>12/16/57</i>		24b. REGISTRAR'S SIGNATURE <i>James H. Casey</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Mem. Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Sebastian</u> First <u>Welch</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1886</u> 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bealy Welch</u>		14. MOTHER'S MAIDEN NAME <u>Lushan Hamell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Myrtle Miller, Waldorf, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12-12-57</u> <u>1951</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> , 19 <u>52</u> , to <u>12-15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-15</u> , 19 <u>57</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city, town, state) <u>La Plata, Md.</u> DATE SIGNED <u>12-16-57</u> ACTUAL SIGNATURE <u>E. J. Edelen</u> M.D. PHYSICIAN'S NAME (Type) <u>E. J. EDELEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 18, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>La Plata, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Health Funeral Home, Waldorf, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>12/20/57</u> 24b. REGISTRAR'S SIGNATURE <u>John H. Gasey</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13064

13069

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO La Plata, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Washington Wills				4. DATE OF DEATH Month December Day 10 Year 1957			
5. SEX male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/1898		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business Executive Del Co.		10b. KIND OF BUSINESS OR INDUSTRY Del Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. Charles Co.	
13. FATHER'S NAME David Wills				14. MOTHER'S MAIDEN NAME Bowling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 100-41		17. INFORMANT Blockbuster Wills LaPlata Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 816x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed Chest DUE TO (c) Auto Accident						INTERVAL BETWEEN ONSET AND DEATH 12-7-10-57 12-2-57 12-2-57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto hit by trailer truck					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:20 p.m. 12		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 301		20f. (City or town) (County) (State) La Plata Ches Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-13-57		22c. NAME OF CEMETERY OR CREMATORY Spry Thomas	
23. FUNERAL DIRECTOR'S SIGNATURE Wheeler Mc LaPlata				24a. REC'D BY REGISTRAR DATE 12/16/57		24b. REGISTRAR'S SIGNATURE Julius H. Pason	
ACTUAL SIGNATURE E. J. EDELEN				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 12-2-57							

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3000

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth	
John Doe		Male		45		White		1910		New York	
Residence		Occupation		Cause of Death		Manner of Death		Date of Death		Place of Death	
123 Main St		Teacher		Heart Disease		Natural		1957		Home	
Physician		Hospital		Coroner		Medical Examiner		Signature		Date	
Dr. Smith		St. Mary's		John Doe		John Doe		[Signature]		1957	

BUREAU V. S.

DEC 19 1957

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 DIVISION OF PUBLIC HEALTH
 BALTIMORE, MARYLAND
 DEC 19 1957

STATE OF MARYLAND—BALTIMORE, 18 Item 11 Film 0223 12-27-57 et CERTIFICATE OF DEATH

13070

13065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 La Plata</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>66 Phy Mem Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Jeane Elaine</i> First Middle Last <i>XATES</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>14</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>17 Feb 57</i>
9. AGE (In years lost birthday) <i>— yrs.</i>		IF UNDER 1 YEAR Months <i>10</i> Days <i>3</i>	IF UNDER 24 HRS. Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>more</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>La Plata, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>William I Yates</i>		14. MOTHER'S MAIDEN NAME <i>Hester Ann Barton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>0</i>		16. SOCIAL SECURITY NO. <i>William I Yates</i>	
17. INFORMANT <i>Saplata md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Collapse</i> <i>241 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Bronchial pneumonia.</i> DUE TO (c) <i>allergic bronchitis.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i> <i>2 days</i> <i>6 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>17 Feb</i> , 19 <i>57</i> , to <i>14 Dec</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>14 Dec</i> , 19 <i>57</i> , and that death occurred at <i>8:00 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. Woody</i> M.D. <i>La Plata, Md.</i>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>ARTHUR O. WOODDY, MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-16-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>	22d. LOCATION (City, town, or county) (State) <i>Saplata md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arhart Inc</i>		24a. REC'D BY REGISTRAR DATE <i>12/17/57</i>	
ADDRESS <i>Saplata md.</i>		24b. REGISTRAR'S SIGNATURE <i>Julia Hasey</i>	

2066313XV6

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED		DATE OF DEATH	
MAYNARD		1957	
PLACE OF DEATH		DATE OF BIRTH	
HOSPITAL		1957	
CITY AND COUNTY		SEX	
BALTIMORE, MARYLAND		MALE	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
OCCUPATION		MARRIAGE	
LABORER		MARRIED	
DATE OF MARRIAGE		CAUSE OF DEATH	
1957		HEART DISEASE	
PLACE OF BIRTH		DATE OF DEATH	
BALTIMORE, MARYLAND		1957	
CITY AND COUNTY		SEX	
BALTIMORE, MARYLAND		MALE	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
OCCUPATION		MARRIAGE	
LABORER		MARRIED	
DATE OF MARRIAGE		CAUSE OF DEATH	
1957		HEART DISEASE	

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